West Nile Case History Form

This **case history form** is required for testing (specimens will not be tested without this form). Please notify **Community Epidemiology (619) 515-6620** before submitting specimens to the Public Health laboratory. Specimens submitted via public health laboratories must meet the criteria for West Nile virus testing. (See" Requirements for West Nile Virus Testing")

Patient Information:

Last name _____ First name_____DOB ____/_____/____ Medical Record #_____

Street Address: _____City _____Zip Code _____Occupation_____
Phone Number _____

Physician Information Mandatory

Name: _____ Facility: _____

Phone # or Pager: _____ Fax: _____ Email: _____

Race: o White o Black o Native American
o Asian/Pacific Islander o Other o Unknown

Date of 1st symptom(s): ____/____/____
o Hospitalized **or** o ER /Outpatient
Date of admit: ____/____/____

Do the following apply anytime during current illness:

In ICU	o No	o Yes
Fever ≥38º	o No	o Yes
Headache	o No	o Yes
Rash	o No	o Yes
Stiff neck	o No	o Yes
Muscle Weakness	o No	o Yes
Altered Consciousness	o No	o Yes
Encephalitis	o No	o Yes
Aseptic Meningitis	o No	o Yes
Flaccid Paralysis Asymmetrical	o No	o Yes o

CSF results

Date: _____
RBC: _____
WBC: _____
%Diff: _____
Protein: _____
Glucose _____

CBC results

Date: _____
WBC: _____
%Diff: _____
HCT: _____
Plt: _____

Other Information (MRI/CT,LFTs etc.)

_____

_____

Ethnicity: o Hispanic o Non-hispanic
Sex: o Female o Male

Exposures within 4 wks of onset (specify details):

Mosquito bites/exposure: o No o Yes

Outdoor activity (camping, hiking, etc) o No o Yes

Received Blood Transfusion: o No o Yes
Date:

Travel within 4 wks of onset

(**specify location**, **dates**):

Within California (out of local area) o No o Yes

Within the United States? o No o Yes

Outside of the United States? o No o Yes

Ever traveled outside the US? o No o Yes

Other pertinent information:

Immunocompromised patient: o No o Yes

Yellow fever vaccination: o No o Yes
Date:

Military service: o No o Yes

Current Pregnancy o No o Yes
Week of gestation:

Donated Blood: o No o Yes
Date:

Significant Past History (medical, social, family) and other exposures:_____

_____

_____

_____

For questions regarding testing of specimens, please contact Jill Giesick or Let Negado (619) 692-8500

Fax this form to **(619) 692-8558** and send with specimens to:
San Diego County Public Health Laboratory
3851 Rosecrans St., San Diego, CA 92110